Better Homes and Centers

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Sensitive Issues

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THE AMERICANS WITH DISABILITIES ACT AFFECTS ALL CHILD CARE PROVIDERS

Mark Sullivan, Director
Michigan 4C Association

In January of 1992, a new Civil Rights Act took effect. The Americans with Disabilities Act (ADA) affects child care providers in two ways: providers may not discriminate against children with disabilities in enrollment and providers may not discriminate against adults with disabilities who apply for employment in a program.

"Day care centers" are referenced specifically under the "Public Accommodations" section of the law, but it appears that the interpretation of "day care center" includes all child care programs: centers, nurseries, cooperative nurseries, Head Start programs, before- and after-school programs, family day care homes and group day care homes.

Enrolling children with disabilities

Under the law, a child care provider may not use eligibility requirements that exclude or segregate individuals with disabilities. A child care program may exclude individuals with disabilities if they pose a direct threat to themselves or others which cannot be mitigated by modifications in policies, practices or procedures or by the provision of auxiliary aids. Furthermore, services must be offered in the most integrated setting appropriate to the needs of the individual. In practical terms, this means making reasonable accommodations in providing auxiliary aids and services when they are necessary to assure effective communication with individuals with hearing, speech or vision impairments; removing barriers when readily achievable and modifying policies, practices and procedures to accommodate children with disabilities. The Americans with Disabilities Act Handbook defines "readily achievable and undue burden as easily accomplishable and able to be carried out without much difficulty or expense." The burden of proof that accommodations were not readily achievable due to an undue burden, falls on the provider.

In addition to not excluding children with disabilities, providers must include the child in all activities which are part of the program.

DIRECTOR'S CORNER

I want to take some time to talk about both the rights and treatment of children. Far too often, children are viewed as objects rather than sensitive, feeling human beings. One of the most serious problems facing today's child, is growing up without self-esteem. Any relationship is at times difficult under the best of circumstances. When a child grows up without feeling good about himself, problems of adjustment within normal relationships become significant and may produce the behavior that we see reflected in the violence around us.

I have had adult providers call me about being in noncompliance and express to me that it does not make them a bad person. Of course it doesn't and I would not want to mix the two. If adults have a hard time separating "bad things" from being a "bad person," think how much more difficult it is for a preschooler to see the difference. Child care providers are in an excellent position to not only treat children with respect but to model good behavior. Provider attitudes, positive and negative, are easily translated to children.

Kids learn from adults and the way adults behave towards them. The time spent in child care can help a child learn the proper way to deal with frustration. We know that a significant number of people who were abused as children become abusers. Calling a child a name, referring to a child in a derogatory manner, or using profanity to express our unhappiness with a certain situation can have an impact on a child's self-concept.

I cannot emphasize enough how strongly I feel about the positive impact providers can have on children. For many children the majority of their waking hours are spent in child care. The opportunities are endless to shape their young lives and to help children feel good about themselves. We need to be sensitive in our reactions to children so we do not damage their fragile egos and view of self.

To parents who have children with special needs, this law is good news. It means that their children will have the same rights and considerations as any other child in a child care program. Their children will be included in activities. Their children will receive the same challenges, discipline and nurturing as the other kids. Their children will be part of the program.

To some providers, the ADA may appear as a threat. It may require rethinking and changing: room arrangements, activities, modifying the space and entrances, staffing, schedules and policies. It will mean learning about children with special needs and how to include these children in the regular program.

If providers take a practical approach to implementing the ADA in their program, the experience may not be so threatening and will likely result in positive outcomes for children and parents. Child care providers are extremely resourceful and creative. Child care providers can turn a throwaway object into a toy. Child care providers know how to turn an unforeseen event into a learning activity. If providers use the same creativity in their approach to working with a child with special needs, the possibilities are endless.

Consider these ideas:

1. Talk with the parent about what the child does well and what the child likes to do. When you have a list of the child's capabilities, it will be easier to see how to include the child in the regular program.
2. Review the space where children play. Consider how adjustments in room arrangement might make it easier for a child to get around. Again, work with the parents! Ask the parents to look around and to assist you in identifying barriers or potential problems and then ask them to help you by suggesting alternatives.
3. Take advantage of the resources available to you. Contact you local 4C office. Most of the 4C offices have child care specialists who have worked with children with special needs. All of the 4C offices can assist you in findings information, training or support services. Contact the local Intermediate School District or the "Early On" coordinator in your area. For the number of the Early On coordinator nearest you, call 1-800-EARLYON or 1-800-327-5966 (voice and tdd). Early On or special education may have services which they can offer to kids at your program site.

Including children with special needs into your program — while it may be a change from the way in which things operated in the past — can have very positive results. All of the children in your program will gain new insights into how other children manage their environment. Working from "strengths" rather than "limitations" can have a positive effect on all aspects of curriculum.

COMING SOON TO YOUR LOCAL OFFICE

I'm excited to announce that with the assistance of a federal grant, the Division has produced a number of media presentations, including videos intended to help strengthen the Department's role in the regulation of child care centers and homes.

We expect to eventually make copies of these available to you through "lending libraries" set up in consultant offices. Some will be used in orientations held by individual consultants and others will be available for licensees to use for in-service training and other purposes. Our interest is to work together with you to improve the overall quality of child care in the state. We hope this media package will be unlimited in its use.

The videos include:

Starting A Child Care Center

Complaints and Concerns

Positive Discipline Environment

Positive Discipline Methods

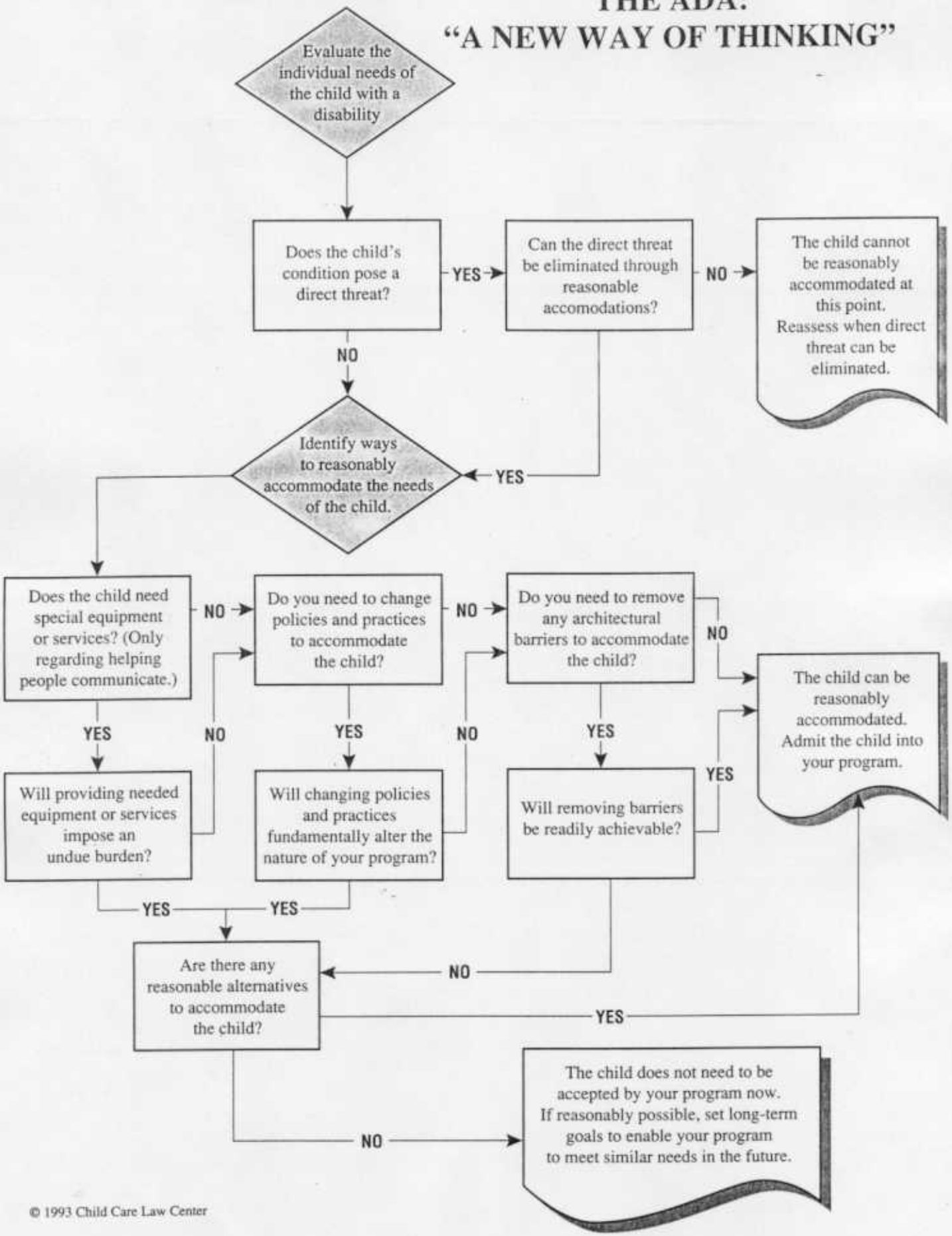
Child Care Center Licensing Rules — Part I (General Provisions)

Infant/Toddler Rules — Part II

Parts 3-7, Transportation, Field Trips and Special Programs

Parts 8-9, Fire Safety and Environmental Health

THE ADA: "A NEW WAY OF THINKING"



CARING FOR CHILDREN EXPOSED TO DRUGS

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The use of legal and/or illegal drugs by a pregnant woman may have significant effects on the child she is carrying. It is a common misconception that all children exposed to drugs prenatally will suffer irreversible damage and will demonstrate a host of abnormal behaviors throughout childhood. Research demonstrates that not all babies exposed to drugs prenatally develop abnormal effects. Further, current research demonstrates that the common effects/behaviors observed most in children prenatally exposed to legal and illegal drugs are influenced by a group of factors and not just the drugs. These include the quality of the child's social environment, family (caregiving) environment and the network of resources available to the child and her family.

The quality of the caregiving environment is an important factor. This is especially true for the proper development of the infant demonstrating effects of prenatal exposure to drugs. Infants, in general, need appropriate nurturance if they are to grow, develop and flourish. Human infants are totally dependent on caregivers to provide them with the nourishment, stimulation, comfort and safety necessary for them to survive and to thrive. A nurturing environment is one in tune with the individual infant, designed by a caregiver who is able to recognize the infant's cues and respond to them promptly. The infant and her caregiver, surrounded by such an environment, develop a warm relationship that supports healthy growth and attachment both physically and emotionally.

Infants affected by prenatal drug exposure have difficulty regulating their responses to environmental stimulation and personal interaction. For example, an infant may not be able to maintain face to face interaction with her caregiver. She may demonstrate this by simply turning away and refusing eye contact or she may lose control quickly and completely and cry frantically. Other indications that the infant can not handle the interaction include yawning, hiccoughing, sneezing and grimacing. The infant may have difficulty regaining a calm state by herself and will need help from her caregiver. Some infants who cannot appropriately process stimulation from their environment retreat into deep sleep. These infants often have to be awakened to feed and to experience controlled interaction with their caregiver and other aspects of their environment.

Interventions with drug exposed infants are designed to increase the infant's ability to integrate her environment. This will promote alertness and increase the ability to engage in interaction with the caregiver. These infants need to be able to interact appropriately with the environment and with people in order to develop their social/emotional, audio/visual and motor skills. It is, therefore, very important that parent or caregiver learn to interact with and stimulate the infant properly.

The infant herself is the one who can, most effectively, lead the caregiver through the activities and interactions the infant can tolerate at a given time. Each infant has a limit as to how much stimulation she can handle. The sensitive caregiver can identify the cues given by the infant and react accordingly. The key to being good at reading infant's cues is being a good observer. The good observer uses all her senses to learn the unique qualities of each infant in her care and identifies routine markers that signal changes or the possibility or changes in the infant's needs.

There are a variety of ways to help prenatally exposed infants reach a level of alertness that will allow them to interact with their caregiver and their environment. It is important that the infant not be permitted to reach a frantic state. When the caregiver recognizes the infant's early distress cues (these may be hiccoughing, increased motor activity, yawns and other cues mentioned above) swaddling the infant securely in a blanket may keep the infant from becoming frantic and help her regain control. A pacifier is another helpful tool. If the infant's oral-motor skill allows it, a pacifier will help the infant comfort herself. Using these two simple techniques the caregiver may help the infant reach a quiet alert state. At this point some activity or interaction appropriate to the infant's tolerance level may be introduced. For instance, holding the infant facing away from the caregiver, begin to talk slowly, soothingly, rhythmically. Observe the infant's reaction and degree of tolerance for this activity. Or hold the swaddled infant facing the caregiver, the infant's head cupped in the caregiver's hands and allow the infant to quietly explore the face. Once again, make careful observations of the infant's reaction, cues that she is tolerating this well or that she is beginning to lose control. Vertical rocking as opposed to the traditional back and forth rocking appears to be comforting to infants exposed prenatally to drugs. It is another good tool to assist these infants to gain or regain control.

Over a period of time the caregiver can gradually increase the amount of stimulation, both interactions and activities, while withdrawing some of the calming techniques. For examples, when the infant is calm, loosen the swaddling blanket. Permit the infant some freedom of movement in a confined space. Be alert for the infant's distress cues and respond by reswaddling. Follow the infant's lead.

In conclusion, it has been clearly demonstrated that early intervention helps these infants recover normal growth and development patterns. A significant force in the infant's recovery is the quality of the relationship between the caregiver and the infant.

REPORTING SUSPECTED CHILD ABUSE OR NEGLECT IN CHILD CARE SETTINGS

Jim Dykstra, Licensing Consultant
Kent County

Will the parent remove the child? Will the parent retaliate by filing a complaint against me? Will I be sued? Will the child get hurt more at home if she tells? What if I'm wrong? Will P.S. do anything anyway? . . . These questions represent many of the feelings a provider encounters when dealing with one of the most sensitive issues in child care — reporting suspected child abuse or neglect.

When you have abuse/neglect concerns about children in your care, you are mandated by the Child Protection Law to make an oral and written report to Children's Protective Services. Making these reports can be frustrating and anguishing for all of us! When you have a concern, you could make some general open-ended inquiries of the children and parents such as "What happened to your back?" or "How did you get that owie?" or "How did this happen?" If the answers make you suspect child abuse, call your licensing consultant or Children's Protective Service worker to review the facts of the situation. Prior to calling, write down the facts as you understand them.

You may remain anonymous, but giving your name and role gives your referral credibility. Although your name is protected by the Child Protection Law, when the referral is investigated, most parents are able to figure out who made the complaint. You are encouraged to discuss your concerns with parents/families to maintain open communication. You can share with parents the reasons you are making the referral, such as to ensure that the families receive necessary help.

Children age 0-5 are the most vulnerable to neglect/abuse and we have a responsibility to help protect them in any way possible.

Reporting of sexual abuse of young children has increased significantly during the last decade. An allegation of sexual abuse is a particularly sensitive issue. Minimize any questioning of children. Contact your day care licensing consultant or Children's Protective Services worker as soon as possible.

When parents have abuse or neglect concerns about children in child care settings, they may call your day care licensing consultant or protective services worker. It is the licensing consultant's responsibility to investigate all allegations of abuse/neglect in child care settings. You can prevent complaints of child abuse/neglect by following licensing rules and maintaining open communications between yourself and the parents.

Child abuse/neglect complaints are investigated promptly by licensing consultants or Children's Protective Services workers. Serious complaints of child abuse and all sexual abuse complaints are also investigated by law enforcement for possible criminal charges.

Whether you are reporting or are being investigated for child abuse/neglect, here are some things you should do:

1. Write down the facts as you understanding them as quickly as possible (time, dates, places).
2. Keep in mind your purpose for making the complaint or why a complaint may have been made against you.
3. Keep calm, don't panic.
4. Report promptly.

THE TEACHER'S ROLE IN FACILITATING A CHILD'S ADJUSTMENT TO DIVORCE

Patsy Skeen and Patrick McKenry

WHAT CAN THE TEACHER TO?

In the Classroom

Team teachers, Harriet Sykes and George Brown, have just discovered that over one-half of the families of their kindergarten children have been involved in divorce. They decide that they want to help the children in their classroom grow through the divorce experience. What can they do?

Be a Careful Observer

1. Look for behavioral cues that help you understand how a child is feeling and what problems and strengths the child might have. Free play, art activities, puppet shows, and individual talks with the child are particularly good opportunities for observation.
2. Observe the child frequently, over a period of time, and in several types of situations such as at quiet time, in group work, alone, in active play, in free play, and at home. Such varied observations allow the teacher to construct a more complete picture of the total child and reduce the likelihood that judgments will be made on the basis of a "bad day."
3. Be a good listener to both verbalization and body language.

Make a Plan

1. When teachers are attempting to understand, predict, and intervene with behavior, it is important to first determine the child's physical, social, emotional, and cognitive developmental levels. A plan can then be developed to meet the child's individual needs. Direct observation, parents, counselors, and relevant literature are good sources of information to use when planning.

Provide Opportunities for Working Through Feelings

1. Help the child recognize and acceptably express feelings and resolve conflict through the use of curriculum activities such as painting, flannel board, clay, drawing pictures, writing experience stories about the child's family, dramatic play, doll play, books about alternate family styles, free play, woodworking, music, and movement.
2. If the child appears to be going through the Kubler-Ross stages, prepare to help the child deal with the feelings in each stage. Give the child time for a resolution in each stage.
3. Allow children the solitude and privacy they sometimes need.
4. Support the establishment of divorce discussion and/or therapy groups for children led by trained leaders or counselors.

Help the Child Understand Cognitively

1. Help the child understand cognitively what his or her situation is, how and why he or she feels, how feelings can be expressed, and the consequences of such expression. Many discussions over an extended period of time will be necessary before such cognitive understanding is established.
2. Provide opportunities for the child to be successful in controlling his or her life. For example, make sure equipment and learning materials are matched to the child's abilities. Tell the child about the sequence of the day's events and notify the child about changes in schedule well ahead of time. Give the child opportunities to make as many choices as he or she can handle.
3. Books and discussions can be used to give information about divorce in general and promote peer acceptance and support for a child from a divorced family.

Maintain a Stable Environment

1. Remain consistent in expectations for the child. This may be the only area of consistency in a rapidly changing and difficult period of a child's life.
2. Although children must be dealt with patiently and might regress to immature forms of behavior at times, avoid overprotecting the child.
3. Even though the child might have problems, he or she should not be allowed to "run wild." Because parents may be having difficulty setting limits for the child, it is extremely important for the classroom teacher to lovingly, but firmly, set reasonable limits for the child's behavior.
4. Make a special effort to love the child. Let the child know that he or she is important and worthwhile through smiles, hugs, praise, and attention to appropriate behaviors. However, avoid "being a mother or father" or allowing the child to become overly dependent upon you since you and the child will separate at the end of the year.
5. Prepare the child for separation from you at the end of the year (or an extended absence from you during the year) by telling the child ahead of time about the separation, why it will occur, and what will happen to the child. A visit to the new teacher and room can be very helpful. The child must be reassured that you are not leaving because he or she is "bad" or because you have stopped loving the child.
6. Encourage the child to work through stressful situations (e.g., a move to a new house) by talking about and role playing the situation in advance.

Examine Your Attitude

1. Avoid expecting a child to manifest certain kinds of problems simply because parents are divorcing. Children are skillful in "reading" adult expectations and often will behave accordingly. Adults might also assume that divorce is the reason for a behavior problem when in actuality other factors are the causes. Children have different reactions to divorce just as they do to all other aspects of life.
2. Examine personal feelings and values about divorce. Feelings and values consciously and unconsciously affect the way teachers interact with children and parents.
3. Try to help each child grow through divorce. Remember that divorce can have the positive effect of ending a highly dysfunctional family and providing growth opportunities for family members.

Working with Parents

Andy Robinson's mother has just told Andy's teacher, Mr. Wang, that she and her husband are going to get a divorce. She is worried about how this will affect Andy and wants to do whatever she can to assist her son. How can Mr. Wang help?

1. Realize that since divorce is a stressful time, teacher-parent communication should be especially supportive and positive.
2. Understand that parents are in a crisis situation and may not be able to attend to parenting as well as you or they would like.
3. Support the parent as an important person about whom you are concerned.
4. Provide books written for both children and adults for the parent to read concerning divorce.
5. Encourage parents to be as open and honest as possible with the child about the divorce and their related feelings.
6. Urge parents to assure their children that divorce occurs because of problems the parents have. The children did not cause the divorce and can not bring the parents back together.
7. Encourage parents to elicit their children's feelings.
8. Assure parents that children will need time to adjust to divorce and that difficulties in the child's behavior do not mean that the child has become permanently psychologically disturbed.
9. Encourage parents to work together as much as possible in their parenting roles even though they are dissolving their couple role. The attitudes that parents display toward each other and their divorce are vital factors in the child's adjustment. The use of the child as messenger or a "pawn" in the couple relationship is particularly harmful to the child.
10. Help alleviate parental guilt by telling parents that their child is not alone. Indicate to parents that there is also evidence that children from stable one-parent families are better off emotionally than children in unstable, conflictual two-parent families.
11. Encourage parents to take time to establish a meaningful personal life both as a parent and as an important person apart from the child. This can be their best gift to their children.
12. Provide an informal atmosphere in which parents can share their problems and solutions.
13. Correctly address notes to parents. "Dear Parent" can be used when you are not sure if the child's parents are divorced or if the mother might have remarried and have a different name from the child.

Excerpted with permission from Young Children NAEYC. July 1980.

HELPING CHILDREN DEAL WITH DEATH

Jerre Cory, Executive Director
Ele's Place, East Lansing

As most adults know, children grieve differently than adults. They are called the "silent grievers" because to most people they look "fine." If you ask a family who has had a death how their children are, their reply quite often is, "fine."

Children who have had a death in their family may appear to be fine, but in fact are grieving. Quite often they want to protect the adults in their life, so they do not grieve openly. It also takes longer for children to process and understand the fact that a person in their life has died. The younger a person is cognitively, the longer this takes.

There are basically 3 tasks for a grieving child:

1. Understanding that the death has occurred.
2. Converting grief to mourning by telling their story over and over.
3. Reconciling this death and integrating this loss into their daily lives.

If children are not permitted to grieve and mourn, they are more likely to:

- commit violent acts of crime
- attempt and complete suicide
- drop out of school
- experiment with drugs and alcohol
- have difficulty forming attachments in their adult life.

To help children deal with their loss, we must be understanding, patient adults. We must always tell the truth, provide safety, listen, and never be shocked or upset by what we hear. Remember, you are setting the tone for their grief work. Try to save your own pain for later, and "wrap around" theirs without stopping them. Don't be a Kleenex pusher or a person who says "don't cry." Use the words dead and death.

There are some developmental differences you need to be aware of. Children up to 5 years old need to know there are 3 reasons people die. They are very, very, very sick, or they are very, very, very old, or their bodies are very, very, very hurt. At this age, they will not understand death is permanent, but we need to answer their question and tell them "Grandma is dead" over and over, even if six months later they ask when Grandma is coming to visit. I explain the part that what we love about a person is always in our hearts.

Children 6-8 have a broader knowledge base and can separate reality from fantasy but may become regressive. They may go back to old behaviors such as thumb sucking, bed-wetting, and wanting to sleep with their parents. Remembers, they are grieving and asking for comfort in their own way.

8, 9 and 10 year olds can understand death is permanent, but may choose not to. The more information they have, the less helpless they feel. At all ages, let the child lead you by asking questions.

5th and 6th graders may become dependent and regressive because they feel out of control. Complicating things, maybe move to another school or developmental stage.

Teens quite often become angry and feel vulnerable. They feel guilty that they are thinking about their own death, and guilty it wasn't them who died. They may have physical symptoms for unexpressed feelings, such as, stomach aches, head aches, leg aches. If they were previously depressed, they may consider suicide. Use your local mental health emergency services immediately if you suspect this.

If a child or a parent of a child in your group dies inform the other parents and provide them with information about the funeral services. If the death affects the children in the program, perhaps you would like to make a memorial garden where the children and adults can leave something or plant something in memory of the person or pet who has died.

Each of us grieves differently. There are no grades in grief, and no time limit. Grieving is a life long experience. Losing someone close changes a person forever. It takes years to integrate this experience and the person who has died will always be missed.

The good news is that children will go on with growing up and that grieving is a healthy normal process. Those of us who grieve are strong, resilient, productive and happy members of our society.

Ele's Place is a Center for children who are grieving, to embrace their loss effectively.

HELPING THE GRIEVING CHILD

Bobbe Ragouzeos
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Each of us tries to answer question about death and dying according to his or her own experiences in life. All such beliefs should be respected. You must know your limits. Remember, it is O.K. to say *"I don't know."*

Responding to the needs of a grieving child means "being there." Each person must let go of his own expectations and try to understand those of the child. Listening is more important than guiding and advising. Stick with the facts and answer questions grieving children have as directly, simply, and honestly as possible. Answer only what the question is asking.

The following guidelines and suggestions may be of assistance to you in working with a grieving student:

1. In talking with a student (or students), use a normal voice and use the words *"dead," "dying,"* and *"death."* Avoid using phrases that soften the blow such as *"went away"* or *"God took him."* This can be confusing and scary.
2. Be simple and straightforward and say: *"I am sorry about your mother's death." "I am concerned and would like to help you." "I don't know what to say."*
3. Be aware that a grieving child is often not well rested due to insomnia, sleep interruptions or dreams.
4. Set aside time to talk with the child when he or she returns to school. Use the deceased person's name, or title (i.e. father, grandma) when referring to him or her.
5. Let the child ask questions. Answer all questions as honestly and simply as possible — no little white lies. If something is not clear, let the child know that, too.
6. Answer only questions, not statements or expressions of feelings. They are to be listened to.
7. Remember that listening means letting the child lead in discussing what he or she feels is important. By listening carefully, it is possible to relate to some of the child's feelings. This will help him to look at and identify his feelings and understand them better.
8. Encourage the child to express his fears and fantasies.
9. Remember that listening to a child when he or she is depressed is particularly hard. But it is not true that listening to and reflecting back depressed feelings will encourage more depression. By listening and accepting these depressed feelings, a child can more on from the depression more quickly.
10. Reassure a child that the death is not his fault. Also, reassure him that death is not contagious and not all his loved ones will soon die.
11. Don't say *"I know just how you feel."* It is possible to relate to a child's feelings and situation, but don't take over those feelings.
12. Be patient. They are still children and may bring up the subject again and again as they try to accept and learn to live with what has happened.
13. Accept the emotions and reactions the child expresses. Do not tell the child how he or she should feel, and do not push empty reassurances on the child.
14. Offer warmth, affection and the assurance of your physical presence.
15. No matter how well intentioned, teachers must not impose their own religious beliefs on students when answering questions. (An exception to this might be in a parochial school.) There are too many variations in religious viewpoints; sharing these in a public school setting could cause deep confusion and fear. If a child expresses his or her religious ideas about death, it's important for the teacher to respect them.
16. Be sensitive to the child's age and level of understanding. Children may lack the words to express their thoughts and feelings.
17. Do not act as if nothing has happened and wait for the student to initiate conversation.
18. Tell stories and read particular books with children that will increase their understanding and acceptance of death.
19. Death is a natural part of life and a natural topic of discussion in the classroom. It is not necessary to wait until the class is touched by death for the topic to be introduced. Use "teachable moments" to include this topic.
20. Do not be afraid of making mistakes. A grieving child will not be destroyed by an error in judgement.

WHEN A CHILD DIES

Kathy Love, Provider
Group Day Care Home
Midland County

Two years ago this November, after 21 years as a day care professional, I had the devastating experience of a ten week old infant in my care dying of diagnosed SIDS (Sudden Infant Death Syndrome). This particular situation was unique because unlike most SIDS cases, we did not lose this child immediately. As a result of very good backup help and my very skilled assistant caregiver, we were able to administer CPR until EMS arrived a few moments later. They were successful in getting a very faint pulse and quickly transported this child to the hospital where he was then placed on a life support system. We were told by the doctors that we had "interrupted" this child's SIDS. The child remained on life support for forty-eight hours. After that time, it became evident that he would never be strong enough to survive without the life support. He was disconnected from the system and died in his mother's arms a short time later. The autopsy showed that he was a perfectly normal child who had fallen victim to this mysterious childhood killer.

In the days that followed, I was constantly reassured by both the doctors and, more importantly, by the child's parents, that there was absolutely no negligence on my part. In fact, they seemed grateful to me for giving them invaluable time with their son that most parents in the same situation are not given. The kindness and concern for me by the parents in their time of grief was overwhelming. We helped each other survive this tragedy.

The days following the baby's death were the most difficult that I can remember. The support that I received from the parents of the other children in my care was instrumental to my own healing process. They trusted me and believed in me; I couldn't have possibly disappointed them. I chose to once again surround myself with the children. They helped me stay focused on the positive things about my profession; they represented hope for the future. Slowly but surely my life has once again returned to normal.

It is my sincere hope that none of you will ever be confronted with an emergency of this magnitude, but as we all know, children are so unpredictable. They do not come with a guarantee. All we can do as providers is prepare ourselves with training and carefully thought out emergency plans. That way, should the worst happen, we will at least have the comfort of knowing we did our very best.

WHERE THE *#!@'s MY PURPLE CRAYON? ESCALATION OF SLANGUAGE IN THE PRESCHOOL SETTING

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St. Mary of the Lake School
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It was a shock some twenty years ago when the elfin four year old with Buster Brown bangs and big brown eyes looked up from his drawing and matter-of-factly demanded of no one in particular, "Where the *#!@'s my purple crayon?" His tablemates and teacher joined in a collective gasp. By today's standards that was mild. The years have passed and the slanguage has escalated.

Now we live in the age of what Dr. Jim Grant calls the "big swears". Whatever happened to childhood's innocence?

Blame it on T.V., the soaps, R-rated movies on cable network or rented for the family VCR, music videos, song lyrics, teenage siblings or whatever the cause, we do have a problem. Many of us — adults and children alike — have become desensitized to obscene, vulgar, violent and volatile vocabulary. What do we do now? How do we react in preschool when inappropriate language tints the air blue?

1. Stay calm. Try not to act shocked. Do not reward negative attention seeking with an over-reaction. Although the little ones don't always know what they are saying means, they do know these words make waves. If this is the first time you have heard a particular child use inappropriate language you may choose to totally ignore the lapse.
2. If the child's outburst has claimed the surprised attention of playmates, quietly remark, "we don't talk like that here at school." Defuse the situation with a quiet chat with the child who used unacceptable language. Attempt to help him identify and name feelings he is experiencing such as anger, fear, frustration. Model appropriate words to express feelings, "you're really mad, furious, enraged, incensed, etc." Children love new words.
3. Divert and distract the child's attention and help him rejoin the classroom's activity as quickly as possible.
4. If the slanguage problem persists, address the issue honestly with the parents and enlist their support in helping the child change this behavior. Be prepared to hear, "Matt/Mary picked that up at school." of course.
5. Post Ogden Nash's poem somewhere to cheer you up when you get discouraged:

   Sticks and stones are hard on bones
   Aimed with angry art.
   Words can sting like anything, but silence breaks the heart.

REFERENCES: Sensitive Issues

ON COPING WITH DEATH

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ARE YOU READY FOR AN EMERGENCY

By Kathleen S. Nixon, Licensing Consultant
Genesee County

All home providers are required to obtain CPR (cardiopulmonary resuscitation) and first aid training. All providers registered or licensed before October 3, 1989 should already have completed the training. Family home providers registered after October 3, 1989 have three years from the effective date of registration to complete the training.

Although you have two to three years to complete the training, we recommend that you complete it as soon as possible The training prepares you to handle emergencies and provides additional safety measures for the children in your care. It also reassures parents of their children's safety. Enrolling now can ensure that you are knowledgeable and prepared to handle emergency situations in the future.

The CPR training must include infant, child and adult levels because there are different techniques for each age group. Licensing rules require written documentation of course completion.

The training must be done by a person certified to be a Red Cross or American Heart Association instructor, or an equivalent trainer approved by the department. Local agencies to contact for these courses include: American Red Cross, American Heart Association, National Safety Council (Green Cross), Medic First Aid of EMP-America, local hospitals and local community education programs.

First aid training must be done by a person certified as a Red Cross instructor or an equivalent trainer approved by the Department of Social Services.

Group providers have additional training requirements and 1 year less to complete them. Group providers licensed before 1989 should have already completed these requirements. If licensed after October 3, 1989, group providers have 2 years to complete. They must complete 20 clock hours of training including the CPR and first aide training described above and at least 8 clock hours in the area of child development. Training resources include community groups, churches, 4C associations, and day care home associations; conferences on early childhood or child development; workshops and courses offered by local or intermediate school districts, colleges and universities.

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